

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2993 CERTIFICATE OF DEATH

02885

Reg. Dist. No. 166

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
CITY Garrett OR and give nearest town) TOWN Oakland		STATE W. Va. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Philippi,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Evans Nursing Home		COUNTY Barbour (If rural give location) STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) Ella		4. DATE (Month) (Day) (Year) OF DEATH Mar ch 21, 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 20, 1871
9. AGE last birthday 84 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edgar Douglas	14. MOTHER'S MAIDEN NAME Prudence Holden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.)	16. SOCIAL SECURITY NO. -----	17. INFORMANT & ADDRESS Cloris Benson	403 Washington St. Cumberland, Md.
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 432.1 IMMEDIATE CAUSE (A) Hypostatic pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Myocardial Heart Disease GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) Cerebralclerosis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Oakland	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 9:25A	
22. I hereby certify that I attended the deceased from Jan 16, 1956, to March 21, 1956, that I last saw the deceased alive on March 21, 1956, and that death occurred at 9:25A.M. from the causes and on the date stated above. SIGNATURE Julia L. Phance			
23. BURIAL, Cremation, REMOVAL (Specify) Burial	DATE THEREOF 3/24/1956	NAME OF CEMETERY OR CREMATORIUM Mt. Vernon Memorial Cem., Philippi, W. Va.	ADDRESS (Street, city, town, state) Oakland, Md.
24. REC'D BY REGISTRAR DATE 3/23/1956	REGISTRAR'S SIGNATURE Julia L. Phance	25. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton	ADDRESS Oakland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

040529

2904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

3 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Garrett

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

d. STREET ADDRESS

Star Route

X

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
HenryMiddle
WilsonLast
Bills4. DATE
OF
DEATHMonth
3Day
30th
Year
19 56

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

4 / 3 / 1890

9. AGE (In years
lost birthday)

65 yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Tobacco

11. BIRTHPLACE (State or foreign country)

Wheeling, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Henry G. Bills

14. MOTHER'S MAIDEN NAME

Mary Jane Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) If yes, give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

World I

17. INFORMANT

052-01-8966 Mrs. Leona Bills

Star Route

Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
Immediate

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Arteriosclerotic Heart Disease

C Hypertension

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from January 19 56 to present 19 56 that I last saw the deceased alive on March 24 19 56, and that death occurred at 4 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

Grantsville, Md. Mar 30/56

PHYSICIAN'S
NAME (Type)

Ruth Peacheay MD.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county)

(State)

Burial

4 / 1 / 1956

Grantsville Cemetery

Grantsville, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

23. E. Main

ADDRESS

Frostburg, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE 4-3-56

Hafer Funeral Home

CERTIFICATE OF DEATH

U. S. STATE DEPARTMENT OF HESIYH - BUREAU OF INVESTIGATION

NAME

ADDRESS

PHONE

TELEGRAM

TELETYPE

BUREAU V. S.

APR 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2905

CERTIFICATE OF DEATH

02886 6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OAKLAND		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRELLIN	
3. NAME OF DECEASED (Type or print) GUS		d. STREET ADDRESS 1	
4. DATE OF DEATH DE LAUDER		Month MARCH	Day 21
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 1, 1873	
9. AGE (In years lost birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN DE LAUDER		14. MOTHER'S MAIDEN NAME ELIZABETH HALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Theresa Wellling		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Anteriosclerotic Heart Disease (c) Senility.		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, 19, to 3-21, 1957, that I last saw the deceased alive on 3-21-, 1957, and that death occurred at 5 P. M., from the causes and on the date stated above. ACTUAL SIGNATURE JAMES H. FEASTER, JR., M.D. ADDRESS (Street, city or town, state) 5824 1/2 St. Oakland, Md. DATE SIGNED 3-21-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Oakland		22d. LOCATION (City, town, or county) Oakland	
23. FUNERAL DIRECTOR'S SIGNATURE Emrys Borden		ADDRESS Oakland, Md.	
24a. REC'D. BY REGISTRAR DATE 3/24/56		24b. REGISTRAR'S SIGNATURE Julia Rowan, L.R.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 29 1956

REGELY ED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2906 CERTIFICATE OF DEATH

02887
02966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) ANNA		First LENA	Middle EGGERS.		
4. DATE OF DEATH Month MARCH.	Month 17	Day 1956	Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH-30-1873		
9. AGE (In years lost birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? U.S.	12. BIRTHPLACE (State or foreign country) OAKLAND		
13. FATHER'S NAME HENRY	14. MOTHER'S MAIDEN NAME MARGARET	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.1	16. SOCIAL SECURITY NO. E. EGgers.		
17. INFORMANT W.E. EGgers.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 420.1	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	19. INTERVAL BETWEEN ONSET AND DEATH 2 hrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) OAKLAND	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 15, 1949 , to March 17, 1956 , that I last saw the deceased alive on March 17, 1956 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE R.E. Mance	ADDRESS (Street, city or town, state) Oakland Md	DATE SIGNED 18 March			
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.	Oakland, Maryland	arch 18, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MARCH-20-1956	22c. NAME OF CEMETERY OR CREMATORIUM OAKLAND CEMETERY	22d. LOCATION (City, town, or county) OAKLAND		
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden	ADDRESS OAKLAND MD.	24a. REC'D BY REGISTRAR DATE 8/25/56	24b. REGISTRAR'S SIGNATURE Julia R. Brown		

CERTIFICATE OF DEATH

BUREAU V. S.
REGEV
MAR 29 1958

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02888

2907 CERTIFICATE OF DEATH

166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Garrett		MARYLAND		STATE West Virginia	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		TOWN Oakland		LENGTH OF STAY (in this place)		COUNTY Preston	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Evans Nursing Home		12 days		CITY (If outside corporate limits, write RURAL and give nearest town)	
90						TOWN Terra Alta	
STREET ADDRESS				STREET ADDRESS		(If rural give location)	
						Washington Avenue	
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
Samuel Elsworth Elsey				March 9, 1956			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Male		White		Married		June 11, 1879	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired Telegraph Operator B&O R R Co		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country)	
76 yrs.						Terra Alta, West Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES?		16. SOCIAL SECURITY NO.	
Benjiman H. Elsey		Almeda DeBerry		(Yes, no, or unk.)		705-12-2699	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY?	
Mrs. Bessie Jeraldine Elsey, Terra Alta		Central Hemorrhage		19b. MAJOR FINDINGS OF OPERATION		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
W Va		Cardio-ventricular disease		7 Old euphyma		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE		(A)		Arteriosclerosis		1 week	
ANTECEDENT CAUSE(S)		DUE TO		Central Hemorrhage 3 wks ago 1st (2nd place giving rise to the above cause stating underlying cause last)		3 yrs	
DISEASES OR CONDITIONS, IF ANY,		(B)				3 yrs	
GIVING RISE TO THE ABOVE CAUSE		DUE TO					
STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 2, 1956</u> to <u>Mar. 9, 1956</u> , that I last saw the deceased alive on <u>Mar. 9, 1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Chas E. Smith</u> ADDRESS (Street, city, town, state) <u>Terra Alta, West Virginia</u> DATE SIGNED <u>3/10/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Burial		March 12, 1956		Terra Alta Cemetery		Terra Alta, W.Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>3/10/56</u>		<u>Julia Moran LP</u>		<u>P. R. Watson</u>		<u>Terra Alta, W.Va.</u>	

STATE OF CALIFORNIA

NOTICE OF FUGITIVE FEE

RECEIVED

STATE OF CALIFORNIA

STATE OF CALIFORNIA

OUTER BOUNDARY

OUTER BOUNDARY

INNER BOUNDARY

INNER BOUNDARY

NOTICE OF FUGITIVE FEE

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NOTICE OF FUGITIVE FEE

BUREAU V. S.

MAR 19 1956

RECEIVED

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2908

CERTIFICATE OF DEATH

02889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OAKLAND		b. COUNTY TUCKER		
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIS 85x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) VERONA		First B.	Middle EUBANK	
4. DATE OF DEATH MARCH 2 19 56	Month Day Year			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH JUNE 25, 1874		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME WILLIAMS, E.F.		14. MOTHER'S MAIDEN NAME GRIMES, MARGARET		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. H. A. MEYER
				Address DAVIS, W.VA.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x				INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO Chronic Nephritis (c) DUE TO Congestive Heart Failure				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19				
21. I certify that I attended the deceased from <u>January 1, 1956</u> to <u>March 2, 1956</u> , that I last saw the deceased alive on <u>March 1, 1956</u> , and that death occurred at <u>50 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. P. Baumgartner</u> M.D. ADDRESS (Street, city or town, State) PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER, M.D. DATE SIGNED <u>3/2/56</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/56	22c. NAME OF CEMETERY OR CREMATORIAL Warm Springs, Va.	22d. LOCATION (City, town, or county) Warm Spring, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		ADDRESS Davis, W.Va.	24a. REC'D BY REGISTRAR DATE 3/7/56	24b. REGISTRAR'S SIGNATURE Julia A. Hawley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S

MAR 7 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02890

2909 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH

COUNTY GARRETT

CITY (If outside corporate limits, write RURAL
OR
give nearest town)
TOWN

OAKLAND

MARYLAND

LENGTH OF STAY
(in this place)

8 days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

10 GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

FRIENDSVILLE

(If rural give location)

STREET
ADDRESS3. NAME OF
DECEASED
(Type or Print)

HARVEY

WILLIAM

(Last)

4. DATE
OF
DEATH

MARCH 25 1956

IF UNDER 1 YEAR
Months Days Hours Min.

5. SEX

M

6. COLOR OR
RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

WIDOWER

8. DATE OF BIRTH

MARCH 22, 1881

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

RETIRED

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME

MARSHALL FIKE

14. MOTHER'S MAIDEN NAME

REBECCA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE

(A)

Cerebral Vascular Accident

INTERVAL BETWEEN
ONSET AND DEATH
3 weeksANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C) Senility

Arteriosclerotic Heart Disease

years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 3.17.1956, 10.3.25.1956, that I last saw the deceased
alive on 3.26.1956, and that death occurred at 12.15 M, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

24. RECD BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

Julia Rowan

Frank D Friend, Friendsville

1
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 2910 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) NEAR SANG RUN, MD.		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE, MARYLAND	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FORD		4. DATE OF DEATH Month Day Year MARCH 22ND. 1956	
First QUINTEN		Middle FRIEND	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 26TH., 1918	
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CORNELIUS WARD FRIEND		14. MOTHER'S MAIDEN NAME LIZZY MAE FRIEND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 20816-4654	
17. INFORMANT OLIN FRIEND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL DUE TO 910.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BROKEN NECK DUE TO (c) CRUSHED CHEST	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CRUSHED VICTIM WHILE WORKING UPON ROCK IN A STONE QUARRY. ROCK SLIDE	
20c. TIME OF INJURY 8:15 a. m. 3-22 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) COUNTY STONE QUARRY SANG RUN GARRETT MD.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster Jr. M.D.</i>		DATE SIGNED MARCH 22, 1956	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D. ACTING DEPUTY MEDICAL EXAMINER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/56	
22c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose		22d. LOCATION (City, town, or county) FRIENDSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack & Friend Friendsville</i>		24a. REC'D BY REGISTRAR DATE March 23 1956	
ADDRESS <i>Mrs. Ruth Frantz</i>		24b. REGISTRAR'S SIGNATURE <i>13930</i>	

EXAMINER'S CERTIFICATE OF RECEIPT

RECEIVED
BUREAU V.

MAR 27 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2911

CERTIFICATE OF DEATH

02892
 02911
 02912
 02916

Reg. Dist. No.

Item 9, Film G194 3-23-56 et

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OAKLAND		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MC HENRY		d. STREET ADDRESS BOX # 29		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle HOWARD	Last GLOTFELTY	4. DATE OF DEATH MARCH 4 1956	Month MARCH	Day 4	Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 12, 1877	9. AGE (In years lost birthday) 78 7/8 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - RETIRED		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME THADEUS GLOTFELTY		14. MOTHER'S MAIDEN NAME MARGARET FRATZ				Address MC HENRY, MARYLAND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO.		17. INFORMANT BLAINE GLOTFELTY				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		b. Hyperarteritis Nigricardal Heart Disease Cerebral Sclerosis		c. 3 years 7 years		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/27/1956 to 3/1/1956, that I last saw the deceased alive on 3/4/1956, and that death occurred at 4:57 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Oakland Rd 4th St		
ACTUAL SIGNATURE ANDREW E. MANCE		M.D.				DATE SIGNED 4/1/56		
PHYSICIAN'S NAME (Type)		ANDREW E. MANCE, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/7/56		22c. NAME OF CEMETERY OR CREMATORIAL THAYERVILLE		22d. LOCATION (City, town, or county) THAYERVILLE, GARRETT Co., MD (State)		
22d. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		ADDRESS GRANTSVILLE, MD		24a. REC'D BY REGISTRAR DATE 3/7/56		24b. REGISTRAR'S SIGNATURE Julia Rowan		

CERTIFICATE OF DEATH

MATERIALS

METHODS

BUREAU V. S.

MAY 9 1956

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02893
 166

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL) RURAL (NEAR SANG RUN, MD.)				c. LENGTH OF STAY IN 1b 12 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS SANG RUN, MARYLAND			
3. NAME OF DECEASED (Type or print) LLOYD NELSON GUARD				First	Middle	Last	4. DATE OF DEATH MARCH 22ND, 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV. 10TH., 1889	9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME FRANK GUARD				14. MOTHER'S MAIDEN NAME MOLLEY TURNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-18-2836		17. INFORMANT MRS. STEPHEN DEWITT, SANG RUN, MD.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL IMMEDIATE 910.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CRUSHED CHEST IMMEDIATE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) ROCK SLIDE CRUSHED VICTIM WHILE WORKING UPON ROCK IN A STONE QUARRY.			
20c. TIME OF INJURY 8:15 a.m.		Month, Day, Year 3-22-56	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) COUNTY STONE QUARRY	20f. (City or town) SANG RUN	(County) GARRETT	(State) MD.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>				DATE SIGNED MARCH 22ND., 1956			
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D. ACTING DEPUTY MEDICAL EXAMINER				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF March 24 1956	22c. NAME OF CEMETERY OR CREMATORIAL Oaklawn	22d. LOCATION (City, town, or county) Sang Run (State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Bolden				ADDRESS Oaklawn	24a. REC'D BY REGISTRAR Julia D. Rowan	24b. REGISTRAR'S SIGNATURE Julia D. Rowan	
				DATE 3/24/56			

BUREAU V. S.

MAR 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04060

Reg. Dist. No. 166

2913

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland.		c. LENGTH OF STAY IN 1b 1-wk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mathis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Benjamin		First Middle Name	Lost Haltermann	4. DATE OF DEATH Mar 19th, 1956	Year 19		
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 16, 1907	9. AGE (In years lost birthday) 48 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Mathias, W.VA.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Liona P. Haltermann		14. MOTHER'S MAIDEN NAME Anna E. See.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Thomas DeLauder, Sister.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH					
352A Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		Atelectasis Rt. Lower Lobe 4 days					
DUE TO Pancreatitis (c)		3 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland, Ind.	(County)	(State)
21. I certify that I attended the deceased from <u>Mar. 2, 1956</u> , to <u>Mar. 5, 1956</u> , that I last saw the deceased alive on <u>Mar. 2, 1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE ARTHUR F. JONES, M.D.		ADDRESS (Street, city or town, state) Oakland, Ind.				DATE SIGNED 3-7-56	
PHYSICIAN'S NAME (Type) ARTHUR F. JONES, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-7-1956	22c. NAME OF CEMETERY OR CREMATORIUM Augusta Cemetery		22d. LOCATION (City, town, or county) Augusta, W.VA.		
23. FUNERAL DIRECTOR'S SIGNATURE John Stansell Home Mortuary		ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE 3/7/56 Julie Rowan LR		

DEPARTMENT OF HUMAN RESOURCES
STATE OF GEORGIA

BUREAU V. 2

APR 9 1956

EL-GEIY EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02894
166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK.		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CO		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) MICHAEL		First A.	Middle MADIGAN.
4. DATE OF DEATH MARCH 17 1956	Month MARCH	Day 17	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5 1866
9. AGE (In years lost birthday) 90 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED B.R.O TRACKMAN.	11. KIND OF BUSINESS OR INDUSTRY DEER PARK.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME MICHAEL MADIGAN.	14. MOTHER'S MAIDEN NAME MARY GOLLIHAN.	Address EDWARD MADIGAN DEER PARK MD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] 420.1			
16. SOCIAL SECURITY NO. EDWARD MADIGAN DEER PARK MD.			
17. INFORMANT EDWARD MADIGAN DEER PARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia due to Anemic Cardiopathy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Anemic Cardiopathy (c) Conway Heart Disease			
INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Xanthoxyl			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1956			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 10412 M.D.
21. I certify that I attended the deceased from Jan , 1956, to March 17 , 1956, that I last saw the deceased alive on March 16 , 1956, and that death occurred at 10412 M.D. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Calandella		ADDRESS (Street, city or town, state) Kitzmiller MD	
PHYSICIAN'S NAME (Type) RALPH CALANDELLA		DATE SIGNED March 18 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 20 1956	
22c. NAME OF CEMETERY OR CREMATORIUM DEER PARK CEMETERY		22d. LOCATION (City, town, or county) DEER PARK	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden OAKLAND		24a. REC'D BY REGISTRAR DATE 3/20/56	
ADDRESS MD.		24b. REGISTRAR'S SIGNATURE Julia Powers JR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 29 1958

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02895

2915 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place) 40 yrs.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 2, Frostburg	COUNTY Garrett (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS					
3. NAME OF DECEASED (Type or Print)	(First) Joseph	(Middle) E.	(Last) McKenzie			
4. DATE (Month) OF DEATH	(Day)	(Year)				
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Nov. 14th, 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clay Miner		10b. KIND OF BUSINESS OR INDUSTRY Fire Clay	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Francis McKenzie		14. MOTHER'S MAIDEN NAME Leahanna Warner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO. 213-10-9896		17. INFORMANT & ADDRESS RFD 2, Box 356 Carl McKenzie, Frostburg, Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		18. MEDICAL CERTIFICATION Acute myocardial infarction Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 min.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Feb. 29, 1956, to March 3, 1956, that I last saw the deceased alive on March 2, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above. SIGNATURE <i>Paige Strong</i> M.D.						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-6-1956	NAME OF CEMETERY OR CREMATORIUM Greenville Cemetery	ADDRESS (Street, city, town, state) Salisbury, Penna. DATE SIGNED March 5, 1956		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mrs. Darcy A. Rea</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R. Durst, Frostburg, Md.			
DATE 3-6-56						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G19, 1-2-56 et

2916

CERTIFICATE OF DEATH

02896
66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Fannie	Middle K	Last Moon
4. DATE OF DEATH March	Month 12	Day 19	Year 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 30, 1877
9. AGE (In years 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Mt. Lake Park, Maryland
13. FATHER'S NAME Abraham Moon	14. MOTHER'S MAIDEN NAME Penelope Hendrickson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. ----	17. INFORMANT Mark H. Moon	Address Mt. Lake Park, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Constrictive Heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemia Deformans</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 10, 1956</u> to <u>March 12, 1956</u> that I last saw the deceased alive on <u>March 11, 1956</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. I. Baumgartner</i> ADDRESS (Street, city or town, state) <i>3566 1/2 Delwood Rd.</i> DATE SIGNED <i>3/14/56</i>			
PHYSICIAN'S NAME (Type) <i>E. I. Baumgartner, M. D., Oakland, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/1956	22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery	22d. LOCATION (City, town, or county) Near Gorman, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Heribert E. Neighton</i>		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE <i>3/14/56</i>
			24b. REGISTRAR'S SIGNATURE <i>Julia Rowan LR</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 9/55 (4)
15M 9/55

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2917

CERTIFICATE OF DEATH

02897
166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. LENGTH OF STAY IN 1b 00		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		d. STREET ADDRESS X MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHN	Middle ROBERT	Last MOON	4. DATE OF DEATH MARCH	Month 8	Day 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE-22-1892		9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DEER PARK.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SOLOMON MOON		14. MOTHER'S MAIDEN NAME ANNA SMITH.				Address RT. 1 OAKLAND MD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-8291		17. INFORMANT MRS HAZEL MOON		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
		(c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 24</u> , 1956, to <u>March 8</u> , 1956, that I last saw the deceased alive on <u>March 8</u> , 1956, and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.		ACTUAL SIGNATURE R. J. Baudman		ADDRESS (Street, city or town, state) 2500 30th Street, Baltimore, MD.		DATE SIGNED 2/10/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH-11-1956		22c. NAME OF CEMETERY OR CREMATORIUM PLEASANT VALLEY CEMETERY		22d. LOCATION (City, town, or county) NEAR OAKLAND MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden		ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR DATE 3/10/56		24b. REGISTRAR'S SIGNATURE Julia Gowan LR	

BUREAU U. S.

1956 67 18

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04068
166

2918

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 3 da.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 GARRETT COUNTY MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK							
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Adam CLARK		First	Middle						
4. DATE OF DEATH		Month	Day						
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/82	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. HOURS	13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED RAILROADER		10b. KIND OF BUSINESS OR INDUSTRY Track work		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Jackson C. JACK RODEHEAVER		14. MOTHER'S MAIDEN NAME VIRGINIA FRIEND							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-9389		17. INFORMANT Lee Rodeheaver		Address Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertensive Cardio-Renal Disease (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland		(County)	(State)
21. I certify that I attended the deceased from March 7, 1955, to March 26, 1956, that I last saw the deceased alive on March 26, 1956, and that death occurred at 12:50 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE A. E. Mance				ADDRESS (Street, city or town, state) Oakland, Md.		DATE SIGNED 26 Mar 56			
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/1956		22c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery		22d. LOCATION (City, town, or county) Deer Park, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. REC'D. BY REGISTRAR 3/28/56		24b. REGISTRAR'S SIGNATURE Jubilee Rowan Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 9 1966
3/28/28 DEG VEL
3/28/28 DEG VEL

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2919 CERTIFICATE OF DEATH

02898
166

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	GARRETT		STATE	MARYLAND	
CITY (If outside corporate limits, write RURAL or and give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)	MARYLAND	
TOWN	OAKLAND		OR	COUNTY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	GARRETT COUNTY MEMORIAL HOSPITAL		TOWN	GARRETT	
			RURAL		SWANTON
			STREET ADDRESS		(If rural give location)
			ROUTE #1		
3. NAME OF DECEASED (First) ALLEN (Middle) C. (Last) RODEHEAVER			4. DATE OF DEATH MARCH 7 1956		
5. SEX M		6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH OCTOBER 30, 1875	9. AGE last birthday 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
Farmer RETIRED					
13. FATHER'S NAME AMI RODEHEAVER			14. MOTHER'S MAIDEN NAME HULDA SMITH		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS Mrs. Freda Boyce Swanton, Md.	
18. MEDICAL CERTIFICATION					
<p>IMMEDIATE CAUSE (A) <i>Bronchitis pneumonia.</i> ANTECEDENT CAUSE(S) DUE TO <i>Myocardial heart disease</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Arteriosclerosis</i> GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Underlying cause last.</i> STATING UNDERLYING CAUSE LAST. DUE TO <i>(C)</i></p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>					
<p>19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION</p> <p>20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></p>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from 3/7/56, 19, to 3/7, 19, 56, that I last saw the deceased alive on 3/7/56, and that death occurred at 8:30 P.M., from the causes and on the date stated above.</p> <p>SIGNATURE <i>Freida Boyce</i> ADDRESS (Street, city, town, state) <i>Deer Park Cemetery, Oakland, Md.</i> DATE SIGNED <i>3/7/56</i></p>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF 3/10/1956		NAME OF CEMETERY OR CREMATORIAL M.D. <i>Deer Park Cemetery</i>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Julia A Rowan</i>		LOCATION (City, town, or county) <i>Deer Park, Md.</i> (State)	
DATE 3/10/56				25. FUNERAL DIRECTOR'S SIGNATURE <i>Freight</i> ADDRESS <i>Oakland, Md.</i>	

DEPARTMENT OF DEFENSE - SECURITY INFORMATION

1910 CERTIFICATE OF DATA

100-2000-000

DATA SOURCE: 100-2000-000

DATA TYPE: 100-2000-000

DATA LEVEL: 100-2000-000

DATA SOURCE: 100-2000-000

DATA TYPE: 100-2000-000

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BUREAU V.

MAR 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12899

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—NEAR GRANTSVILLE, MD.		c. LENGTH OF STAY IN 1b 8 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—NEAR GRANTSVILLE, MD.	
d. STREET ADDRESS STAR RT., FROSTBURG, MD.		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle SCHOMBERT	Last
4. DATE OF DEATH	Month MARCH	Day 19th.	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUGUST 21st. 1878
9. AGE (In years from birth) 77		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING RECENTLY — RETIRED COAL MINER		11b. KIND OF BUSINESS OR INDUSTRY GARRETT COUNTY, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE SCHOMBERT	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 213-09-6524		17. INFORMANT WILLIAM PLATTER STAR RT., FROSTBURG, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		DATE SIGNED 3-19-56	
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR. ACTING		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3/21/56		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS GRANTSVILLE	
22d. LOCATION (City, town, or county) GRANTSVILLE, GARRETT CO. MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		24a. REC'D BY REGISTRAR DATE MAR 22 1956	
ADDRESS GRANTSVILLE, MD.		24b. REGISTRAR'S SIGNATURE d. H. Hedrich	

UNIVERSITY STATE POLICE DEPARTMENT OF MASSACHUSETTS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.
MAR 22 1966
RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02900

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE	
3. NAME OF DECEASED (Type or print) LEROY WHITE		First L	Middle E
4. DATE OF DEATH MARCH 3 1956		Last H	Month MARCH Day 3 Year 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH MARCH 13 1935
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Timber Industry Friendsville	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Dayton Uphold		14. MOTHER'S MAIDEN NAME Meale Savage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-3773	
17. INFORMANT Cecil Savage		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 891.5 DUE TO CARBON MONOXIDE POISONING	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in contact w/ (or from auto & house	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/3 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Friendsville (County) Garrett (State) MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E.I. BAUMGARTNER		DATE SIGNED 3/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/56	
22c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose		22d. LOCATION (City, town, or county) (State) No Friendsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack D Friend, Friendsville		24a. REC'D BY REGISTRAR DATE Feb. 5, 1956 Mrs Ruth Franklin	
ADDRESS 100		24b. REGISTRAR'S SIGNATURE Dec. 5	

BUREAU V. S.

MAR 7 1956

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2922 CERTIFICATE OF DEATH

02901

Reg. Dist. No. 171

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Accident, Md.		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md.		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OT						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MONROE		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1889	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY own farm		11. BIRTHPLACE (State or foreign country) Holmes Co., Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Yoder				14. MOTHER'S MAIDEN NAME Amanda Barkman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Ray Yoder, Accident, R.D. Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO { (c)		Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
DUE TO Diabetes Mel.						5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County)	(State)
21. I certify that I attended the deceased from _____ 1 Mar., 1956, to _____ 10 Mar., 1956, that I last saw the deceased alive on _____ 9 Mar., 1956, and that death occurred at 10:15 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. H. Hoke Jr. MD</i>						ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED 10 Mar. 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 13, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Maple Grove		22d. LOCATION (City, town, or county) Grantsville, Garrett Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald J. Newman</i>		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR DATE Mar. 13, 1956		24b. REGISTRAR'S SIGNATURE <i>J. B. Emory R.</i>			

STATE OF NEW YORK - SALVATION ARMY
CERTIFICATE OF DEATH

BUREAU Y. S

MAR 14 1956

RECEIVED
BUREAU Y. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)5
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02902/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Friendsville, Md.		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P. O. Address Terra Alta, R F D # 1, W.Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) on County Road near Friendsville, Md.		d. STREET ADDRESS d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First RALPH	Middle HENRY	Last VAN SICKLE
4. DATE OF DEATH	Month MARCH	Day 3	Year 1936
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1915
9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR 5	11. IF UNDER 24 HRS. 12	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner Repairman		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) Friendsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis VanSickle		14. MOTHER'S MAIDEN NAME Louetta Kelly	
15. WAS EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 8/10/42-11/18/45 235-20-8324	
17. INFORMANT Mrs. Louetta Kelly VanSickle, Terra Alta		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 891.5 CARBON MONOXIDE POISONING DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH W.H.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) injury to CO from auto exhaust			
20c. TIME OF INJURY Month, Day, Year 3/3 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work at County Road near Friendsville Garrett Md.	
20e. PLACE OF INJURY (Home, farm, factory, street, office block, etc.) near Friendsville Garrett Md.		(County) Garrett (State) W. Va.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE E. I. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/3/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF March 6, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Blooming Rose Cemetery Terra Alta, W.Va.		22d. LOCATION (City, town, or county) near Friendsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Allanson		24a. REC'D BY REGISTRAR DATE 3/6/56 Julie J. Roman	
		24b. REGISTRAR'S SIGNATURE	

DEPARTMENT OF DEFENSE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02903/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) SANG RUN, MD.		c. LENGTH OF STAY IN 1b LIFETIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, OAKLAND, MARYLAND		d. STREET ADDRESS STAR ROUTE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First RANDALL	Middle DWAIN	Last WILBURN	4. DATE OF DEATH MARCH 22ND, 1956	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 8TH., 1913	9. AGE (in years last birthday) 43	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME (FIRST AND MIDDLE UNK.)			14. MOTHER'S MAIDEN NAME SADIE WI LBURN			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 22-028-9373		17. INFORMANT MRS. JAMES WILBURN		Address STAR RT., OAKLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED CHEST INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE								
910.2 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BROKEN RT. SHOULDER								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ROCK SLIDE CRUSHED VICTIM WHILE WORKING UPON ROCK IN A STONE QUARRY.						
20c. TIME OF INJURY Month, Day, Year 8:15 a. m. 3-22 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) COUNTY STONE QUARRY SANG RUN GARRETT MD.		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		DATE SIGNED MARCH 22ND., 1956						
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D. ACTING		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 25, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Thurgerville		22d. LOCATION (City, town, or county) near oakland md		
23. FUNERAL DIRECTOR'S SIGNATURE Enroy Bolder Oakland Md		ADDRESS		24a. REC'D BY REGISTRAR Julia Brown		24b. REGISTRAR'S SIGNATURE		
DATE 3/25/56				DATE				

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S OFFICE - ST. LOUIS, MO.

BUREAU V. S.
RECEIVED
MAR 29 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, FilmG19, J-3-56 et

2925

CERTIFICATE OF DEATH

02904166
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b LIFETIME.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First MARTHA	Middle WOLF.
4. DATE OF DEATH MARCH 15 1956		Last 1871	Month 1871
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-16-1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND MD.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME SAMUEL WOLF		14. MOTHER'S MAIDEN NAME MATILDA WOLF.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. JOSEPH KIENHOFER CUMBERLAND		Address MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio - vascula			
DUE TO (c) disease			
INTERVAL BETWEEN ONSET AND DEATH 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Circa 1958 to 15 March 1956 that I last saw the deceased alive on 15 March 1956 , and that death occurred at 2150A M , from the causes and on the date stated above. ACTUAL SIGNATURE: Thomas F. Lusby ADDRESS (Street, city or town, state) Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 17-1956	
22c. NAME OF CEMETERY OR CREMATORIUM OAKLAND CEMETERY		22d. LOCATION (City, town, or county) OAKLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Golden		24a. REGD BY REGISTRAR DATE 3/17/56	
ADDRESS OAKLAND MD.		24b. REGISTRAR'S SIGNATURE Julia A. Rowan	

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED

MAR 27 1956

3 (12) 67-1000-17

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04075/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Jersey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Crellin		c. LENGTH OF STAY IN 1b Imlayestown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Teena		4. DATE OF DEATH Month Day Year March, 31, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1946
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Imlayestown, N. J.	
11. BIRTHPLACE (State or foreign country) Imlayestown, N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Young		14. MOTHER'S MAIDEN NAME Florence Sisler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 823X		16. SOCIAL SECURITY NO. 17. INFORMANT William Young, Imlayestown, N. J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		1. Crushing injuries right chest wall with rupture of lung. 2. Fracture Basal portion right skull 3. Fracture shaft right femur, left radius & ulna, right mandible.	
		INTERVAL BETWEEN ONSET AND DEATH Instant.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARILY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile skidded and ran into tree.	
20c. TIME OF INJURY Hour 9:00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State route 39	
		20f. (City or town) near Crellin Garrett Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 3/31/56	
ACTUAL SIGNATURE E. I. Baumgartner M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-4-1956		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Green Wood.	
22d. LOCATION (City, town, or county) Allentown, New Jersey		(State)	
22e. FUNERAL DIRECTOR'S SIGNATURE Ernest Goldstein Oaklawn Md.		24a. REC'D BY REGISTRAR DATE 4/15/56	
		24b. REGISTRAR'S SIGNATURE J. H. Powers	

WISCONSIN STATE BOARDMENT OF HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V.

APR 24 1956

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